

**CARDIAC RHYTHM MANAGEMENT SYSTEM SELECTING
BETWEEN MULTIPLE SAME-CHAMBER ELECTRODES FOR
DELIVERING CARDIAC THERAPY**

5

Technical Field

The present system relates generally to cardiac rhythm management systems and particularly, but not by way of limitation, to such a system selecting between multiple same-chamber electrodes for delivering cardiac therapy.

10

Background

When functioning properly, the human heart maintains its own intrinsic rhythm based on physiologically-generated electrical impulses. It is capable of pumping adequate blood throughout the body's circulatory system. Each complete cycle of drawing blood into the heart and then expelling it is referred to as a cardiac cycle.

15

However, some people have abnormal cardiac rhythms, referred to as cardiac arrhythmias. Such arrhythmias result in diminished blood circulation. One mode of treating cardiac arrhythmias uses drug therapy. Drugs are often effective at restoring normal heart rhythms. However, drug therapy is not always effective for treating arrhythmias of certain patients. For such patients, an alternative mode of treatment is needed. One such alternative mode of treatment includes the use of a cardiac rhythm management system. Such systems are often implanted in the patient and deliver therapy to the heart.

20

25

Cardiac rhythm management systems include, among other things, pacemakers, also referred to as pacers. Pacers deliver timed sequences of low energy electrical stimuli, called pace pulses, to the heart, such as via an intravascular leadwire or catheter (referred to as a "lead") having one or more electrodes disposed

in or about the heart. Heart contractions are initiated in response to such pace pulses (this is referred to as “capturing” the heart). By properly timing the delivery of pace pulses, the heart can be induced to contract in proper rhythm, greatly improving its efficiency as a pump. Pacers are often used to treat patients with bradyarrhythmias, that is, hearts that beat too slowly, or irregularly. Such pacers may also coordinate
5 atrial and ventricular contractions to improve pumping efficiency.

Cardiac rhythm management systems also include defibrillators that are capable of delivering higher energy electrical stimuli to the heart. Such defibrillators also include cardioverters, which synchronize the delivery of such stimuli to portions of sensed intrinsic heart activity signals. Defibrillators are often
10 used to treat patients with tachyarrhythmias, that is, hearts that beat too quickly. Such too-fast heart rhythms also cause diminished blood circulation because the heart isn’t allowed sufficient time to fill with blood before contracting to expel the blood. Such pumping by the heart is inefficient. A defibrillator is capable of delivering a high energy electrical stimulus that is sometimes referred to as a
15 defibrillation countershock, also referred to simply as a “shock.” The countershock interrupts the tachyarrhythmia, allowing the heart to reestablish a normal rhythm for the efficient pumping of blood. In addition to pacers, cardiac rhythm management systems also include, among other things, pacer/defibrillators that combine the functions of pacers and defibrillators, drug delivery devices, and any other
20 implantable or external systems or devices for diagnosing or treating cardiac arrhythmias.

One problem faced by physicians treating cardiovascular patients is the treatment of congestive heart failure (also referred to as “CHF”). Congestive heart failure, which can result from long-term hypertension, is a condition in which the
25 muscle in the walls of at least one of the right and left sides of the heart deteriorates. By way of example, suppose the muscle in the walls of left side of the heart deteriorates. As a result, the left atrium and left ventricle become enlarged, and the

heart muscle displays less contractility. This decreases cardiac output of blood through the circulatory system which, in turn, may result in an increased heart rate and less resting time between heartbeats. The heart consumes more energy and oxygen, and its condition typically worsens over a period of time.

In the above example, as the left side of the heart becomes enlarged, the
5 intrinsic electrical heart signals that control heart rhythm may also be affected. Normally, such intrinsic signals originate in the sinoatrial (SA) node in the upper right atrium, traveling through electrical pathways in the atria and depolarizing the atrial heart tissue such that resulting contractions of the right and left atria are triggered. The intrinsic atrial heart signals are received by the atrioventricular (AV)
10 node which, in turn, triggers a subsequent ventricular intrinsic heart signal that travels through specific electrical pathways in the ventricles and depolarizes the ventricular heart tissue such that resulting contractions of the right and left ventricles are triggered substantially simultaneously.

In the above example, where the left side of the heart has become enlarged
15 due to congestive heart failure, however, the conduction system formed by the specific electrical pathways in the ventricle may be affected, as in the case of left bundle branch block (LBBB). As a result, ventricular intrinsic heart signals may travel through and depolarize the left side of the heart more slowly than in the right side of the heart. As a result, the left and right ventricles do not contract
20 simultaneously, but rather, the left ventricle contracts after the right ventricle. This reduces the pumping efficiency of the heart. Moreover, in LBBB, for example, different regions within the left ventricle may not contract together in a coordinated fashion.

For these and other reasons, there is a need to provide cardiac rhythm
25 management therapy that coordinates the timing of contractions of different sides of the heart, and/or alters the conduction of a depolarization through a single chamber of the heart to improve the efficiency of a contraction associated with that heart

chamber.

Summary

This document discusses a cardiac rhythm management system that selects one of multiple electrodes associated with a particular heart chamber. Subsequent contraction-evoking stimulation therapy is delivered from the selected electrode.

5 Both methods and apparatuses are discussed.

In one embodiment, the electrode is selected based on a relative timing between detection of a same fiducial point of a cardiac depolarization at the multiple electrodes. The electrode that is last to detect the fiducial point is selected for subsequent delivery of contraction-evoking stimulations.

10 In another embodiment, a reference first chamber depolarization fiducial point is detected. A second chamber depolarization fiducial point is detected at each of multiple second chamber electrodes during the same cardiac cycle as the reference fiducial point. Time intervals are measured between the reference fiducial point and each of the second chamber fiducial points. The electrode corresponding
15 to the longest such time interval is selected for subsequent delivery of contraction-evoking stimulations.

In a further embodiment, a first depolarization fiducial point is detected from the first heart chamber. During the same cardiac cycle, a second depolarization point is detected from a first electrode associated with the second heart chamber. A
20 first time interval is measured between the first and second fiducial points. During a subsequent cardiac cycle, a third fiducial point, of the same nature as the first fiducial point, is detected from the first heart chamber. During the same cardiac cycle, a fourth fiducial point, of the same nature as the second fiducial point, is detected from a second electrode associated with the second heart chamber. A
25 second time interval is measured between the third and fourth fiducial points. The electrode corresponding to the longer of the first and second time intervals is selected for subsequent delivery of contraction-evoking stimulations.

In yet a further embodiment, a reference fiducial point is detected, over one or more cardiac cycles, from one of a plurality of electrodes associated with a heart chamber. During the one or more cardiac cycles, corresponding fiducial points associated with heart depolarizations are detected at the electrodes, and time intervals are measured between the heart depolarization fiducial points and the
5 respective reference fiducial points. The electrode associated with the longest time interval is used for subsequent delivery of stimulations. Other aspects of the present system and methods will become apparent upon reading the following detailed description of the invention and viewing the drawings that form a part thereof.

10

Brief Description of the Drawings

In the drawings, which are not necessarily drawn to scale, like numerals describe substantially similar components throughout the several views. Like numerals having different letter suffixes represent different instances of substantially similar components. The drawings illustrate generally, by way of example, but not
15 by way of limitation, various embodiments discussed in the present document.

Figure 1 is a schematic/block diagram illustrating generally, among other things, one embodiment of portions of a cardiac rhythm management system and an environment in which it is used.

Figure 2 is a graph illustrating generally, among other things, one technique
20 of selecting between multiple electrodes associated with the same heart chamber.

Figure 3 is a graph illustrating generally, among other things, a technique of acquiring data over a plurality of cardiac cycles for selecting between multiple electrodes associated with the same heart chamber.

Figure 4 is a schematic/block diagram illustrating generally, among other
25 things, another embodiment of portions of a cardiac rhythm management system and an environment in which it is used.

Figure 5 is a graph illustrating generally, among other things, another

technique of selecting between multiple electrodes associated with the same heart chamber.

Figure 6 is a graph illustrating generally, among other things, another technique of selecting between multiple electrodes associated with the same heart chamber, using time intervals obtained during different cardiac cycles.

5 Figure 7 is a graph example of selecting one of electrodes associated with the same heart chamber using time intervals measured from a reference fiducial point obtained from one of the same electrodes associated with that heart chamber.

Detailed Description

10 In the following detailed description, reference is made to the accompanying drawings which form a part hereof, and in which is shown by way of illustration specific embodiments or examples. These embodiments may be combined, other embodiments may be utilized, and structural, logical and electrical changes may be made without departing from the spirit and scope of the present invention. The
15 following detailed description is, therefore, not to be taken in a limiting sense, and the scope of the present invention is defined by the appended claims and their equivalents.

 The present methods and apparatus are described with respect to implantable cardiac rhythm management (CRM) devices, such as pacemakers,
20 cardioverter/defibrillators, pacer/defibrillators, and multi-chamber and/or multi-site (in a single or multiple heart chambers) cardiac resynchronization therapy (CRT) devices. Such CRT devices are included within CRM devices even though the CRT devices need not necessarily modulate heart rate. Such CRT devices may instead
25 provide contraction-evoking stimulations that establish or modify the conduction path of propagating depolarizations to obtain more efficient pumping of the heart. Moreover, the present methods and apparatus also find application in other implantable medical devices, and in unimplanted (external) devices, including, but

not limited to, external pacemakers, cardioverter/defibrillators, pacer/defibrillators, multi-chamber and/or multi-site CRT devices, monitors, programmers and recorders, whether such devices are used for providing a diagnostic, a therapy, or both.

Figure 1 is a schematic/block diagram illustrating generally one embodiment of portions of the present cardiac rhythm management system **100** and an environment in which it is used. In this embodiment, system **100** includes, among other things, cardiac rhythm management device **105**, which is coupled by leads **110A-B** to heart **115**. Heart **115** includes four chambers: right atrium **115A**, right ventricle **115B**, left atrium **115C**, and left ventricle **115D**. Heart **115** also includes a coronary sinus **115E**, a vessel that extends from right atrium **115A** toward the left ventricular free wall, and which, for the purpose of this document, is considered to include the great cardiac vein and/or tributary vessels.

In one embodiment, lead **110A** includes an electrode associated with right atrium **115A**, such as tip electrode **120** and/or ring electrode **125**. The electrode is “associated” with the particular heart chamber by inserting it into that heart chamber, or by inserting it into a portion of the heart’s vasculature that is close to that heart chamber, or by epicardially placing the electrode outside that heart chamber, or by any other technique of configuring and situating an electrode for sensing signals and/or providing therapy with respect to that heart chamber. Lead **110B**, which is introduced into coronary sinus **115E** and/or the great cardiac vein or one of its tributaries, includes one or a plurality of electrodes associated with left ventricle **115D**, such as electrodes **130** and **135**. Device **105** may also include other electrodes, such as housing electrode **150** and/or header electrode **155**, which are useful for, among other things, unipolar sensing of heart signals or unipolar delivery of contraction-evoking stimulations in conjunction with one or more of the electrodes **120**, **125**, **130**, and **135** associated with heart **115**. Alternatively, bipolar sensing and/or therapy may be used between electrodes **120** and **125**, between

electrodes **130** and **135**, or between one of electrodes **130** and **135** and another closely situated electrode.

Device **105** includes a sensing module **160**, which is coupled to one or more of the electrodes for sensing electrical depolarizations corresponding to heart chamber contractions. Such electrical depolarizations of the heart tissue include

5 atrial depolarizations, referred to as P-waves, and ventricular depolarizations, referred to as QRS complexes. The QRS complex is a rapid sequence of several signal excursions away from a baseline in sequentially switching polarity, with the largest excursion referred to as an R-wave. Peak detector **165** is coupled to sensing module **160** for detecting the P-wave peak from right atrium **115A**, obtained by

10 bipolar sensing between electrodes **120** and **125** or by any other sensing technique. Peak detector **165** also senses the R-wave peak at a plurality of different sites associated with left ventricle, such as at each of electrodes **130** and **135**. In one example, electrode **130** is located near the left ventricular apex and electrode **135** is located near the left ventricular base region, i.e., closer to the left atrium **115C**. In

15 another example, one of these two electrodes **130** and **135** (or an additional third electrode) is located in a middle portion (“midregion”) of left ventricle **115D** between the left ventricular apex and the left ventricular base region. In another example, electrodes **130** and **135** are located in a middle cardiac vein and closer to a septum region. The electrodes are located either on the free wall and/or the anterior

20 wall of the ventricle. Sensing at electrodes **130** and **135** is either unipolar (e.g., the electrode **130** and/or **135** is sensed in combination with a relatively distant electrode, such as one or both of housing electrode **150** and/or header electrode **155**) or bipolar (e.g., the electrode **130** and/or **135** is sensed in combination with another relatively close electrode, such as another electrode disposed on lead **110B** and associated with

25 left ventricle **115D**, or another electrode disposed on lead **110A** and associated with right atrium **115A**). System **100** also includes a telemetry transceiver **185** in device **105**, which is communicatively coupled to an external programmer **190**.

Figure 1, and the graph of Figure 2, illustrates an embodiment in which timer 170 measures a first right atrium to left ventricle (RA-LV) time interval between the detection of an intrinsic P-wave at time t_0 at electrode 120 and the subsequent detection during the same cardiac cycle of an intrinsic R-wave peak at time t_1 at first left ventricular electrode 130. A cardiac cycle includes both an atrial and the resulting ventricular heart contraction, and may be measured between P-waves, between R-waves, or between any other fiducial points on a heart signal, where the fiducial point occurs once per cardiac cycle. Timer 170 also measures a second RA-LV time interval between the detection of the intrinsic P-wave at time t_0 at electrode 120 and the subsequent detection during the same cardiac cycle of an intrinsic R-wave peak at time t_2 at a second left ventricular electrode 135. Controller 175 is coupled to timer 170 to receive these first and second time intervals $(t_1 - t_0)$ and $(t_2 - t_0)$, respectively.

Based on a comparison between these time intervals, controller 175 selects one of electrodes 130 and 135 to which therapy module 180 is coupled for delivering subsequent contraction-evoking stimulation therapy to left ventricle 115D. In this example, controller 175 selects the one of electrodes 130 and 135 that corresponds to a longer detected time interval between the detection of the P-wave associated with the right atrium 115A and the detection of the R-wave associated with left ventricle 115D. Thus, if $(t_1 - t_0) > (t_2 - t_0)$, then electrode 130 is selected for delivering contraction-evoking stimulations. If $(t_1 - t_0) < (t_2 - t_0)$, then electrode 135 is selected for delivering contraction-evoking stimulations. If $(t_1 - t_0) = (t_2 - t_0)$, then, in one example, the electrode that is closest to the apex of heart 115 (e.g., electrode 130) is selected for delivering contraction-evoking stimulations. In a further example, a threshold time difference, Δt , is used for making the comparison. In this example, if $(t_1 - t_0) > [(t_2 - t_0) + \Delta t]$, then electrode 130 is selected for delivering stimulations. If $[(t_1 - t_0) + \Delta t] < (t_2 - t_0)$, then electrode 135 is selected for delivering stimulations. Otherwise, electrode 130, or other electrode closest to the apex of

heart **115**, is selected for delivering stimulations. In one example, Δt is approximately between 0 milliseconds and 20 milliseconds inclusive, such as about 10 milliseconds. In a further example, an indication of which of electrodes **130** and **135** was selected is communicated from device **105** by transceiver **185** to external programmer **190** for display to a user.

5 In an alternate embodiment, the reference time t_0 is not used, but the relative times t_1 and t_2 are instead compared directly. If $t_1 > t_2$, then electrode **130** is selected for delivering contraction-evoking stimulations, if $t_1 < t_2$, then electrode **135** is selected for delivering contraction-evoking stimulations, if $t_1 = t_2$, then electrode **130**, or other electrode closest to the apex of heart **115**, is selected for delivering
10 contraction-evoking stimulations. In a further example, a threshold time difference, Δt , is used for making the comparison. For example, if $t_1 > (t_2 + \Delta t)$, then electrode **130** is selected for delivering stimulations, if $(t_1 + \Delta t) < t_2$, then electrode **135** is selected for delivering stimulations, otherwise electrode **130**, or other electrode closest to the apex of heart **115**, is selected for delivering stimulations.

15 In another alternate embodiment, a reference time is used, but this reference time and the times t_1 and t_2 are measured during different cardiac cycles. During a first cardiac cycle, a P-wave is detected at electrode **120** at time t_{0A} and an R-wave is detected at electrode **130** at time t_1 , and a time interval $(t_1 - t_{0A})$ is measured based on these detections. During a second cardiac cycle, another P-wave is detected at
20 electrode **120** at time t_{0B} , and an R-wave is detected at electrode **135** at time t_2 , and a time interval $t_2 - t_{0B}$ is measured. The time intervals $(t_1 - t_{0A})$ and $(t_2 - t_{0B})$ are then compared, as discussed above, for selecting one of electrodes **130** and **135** for delivering stimulations.

 In another alternate embodiment, a left atrial (LA) electrode is substituted for
25 the right atrial electrode **120**, and LA-LV time intervals are measured at each of the LV electrodes **130** and **135**.

Figure 3 is a graph illustrating generally another embodiment in which the P-

R time intervals of interest are evaluated over a plurality of cardiac cycles for determining which of electrodes 130 and 135 to select for delivering therapy. In one example, a statistic, such as an average (or median or otherwise lowpass filtered value) over n consecutive or nonconsecutive intrinsic cardiac cycles, is computed for the P-R1 intervals detected between electrode 130 and electrode 120, and for the P-R2 intervals detected between electrode 135 and electrode 120. If the average P-R1 interval exceeds the average P-R2 interval, either absolutely or alternatively by a predetermined threshold time Δt , then electrode 130 is selected for delivering subsequent contraction-evoking stimuli. If the average P-R2 interval exceeds the average P-R1 interval, either absolutely or alternatively by a predetermined threshold time Δt , then electrode 135 is selected for delivering subsequent contraction-evoking stimuli. If the average P-R2 interval is equal to the average P-R1 interval, or alternatively the difference between these average intervals is less than or equal to the threshold time Δt , then the electrode closest to the apex of heart 115, such as electrode 130, is selected for delivering subsequent contraction-evoking stimuli.

In one embodiment, after such therapy is delivered over several cardiac cycles, then the therapy is occasionally or periodically (e.g., hourly, daily, monthly) turned off (either automatically or manually) for again performing one of the techniques described herein to determine which of electrodes 130 and 135 to provide therapy from during a subsequent time period.

Similar statistical techniques are used in an embodiment in which the selection of one of electrodes 130 and 135 for delivering contraction-evoking stimulations is based on the relative time of occurrence of depolarization fiducial points at electrodes 130 and 135, without using a reference point such as the P-wave. In one such example, the depolarization fiducial point is detected at both electrodes 130 and 135 over several consecutive or nonconsecutive cardiac cycles. If, on average, the depolarization fiducial point (e.g., R-wave peak) of a given

cardiac cycle is detected at electrode **130** before it is detected at electrode **135**, then electrode **135** is selected for delivering subsequent contraction-evoking stimulations, otherwise, electrode **130** is selected for delivering subsequent contraction-evoking stimulations. If, on average, the depolarization fiducial point (e.g., R-wave peak) of a given cardiac cycle is detected at electrode **130** at the same time that it is detected
5 at electrode **135**, then the electrode that is closest to the apex of heart **115**, such as electrode **130**, is selected. Moreover, such comparisons may use a threshold time such as discussed above.

Figure **4** is a schematic/block diagram of one alternate embodiment including right ventricular electrodes, such as tip electrode **400** and ring electrode
10 **405**. Figure **4**, and the graph of Figure **5**, illustrates an embodiment in which timer **170** measures a first right ventricle to left ventricle (RV-LV) time interval between the detection of an intrinsic R-wave peak at time t_0 at right ventricular electrode **400** and the subsequent detection during the same cardiac cycle of an intrinsic R-wave peak at time t_1 at first left ventricular electrode **130**. Timer **170** also measures a
15 second RV-LV time interval between the detection of the intrinsic R-wave peak at time t_0 at right ventricular electrode **400** and the subsequent detection during the same cardiac cycle of an intrinsic R-wave peak at time t_2 at a second left ventricular electrode **135**. Controller **175** is coupled to timer **170** to receive these first and second time intervals $(t_1 - t_0)$ and $(t_2 - t_0)$, respectively.

20 Based on a comparison between these time intervals, controller **175** selects one of electrodes **130** and **135** to which therapy module **180** is coupled for delivering subsequent contraction-evoking stimulation therapy to left ventricle **115D**. In this example, controller **175** selects the one of electrodes **130** and **135** that corresponds to a longer detected RV-LV time interval between the detection of the
25 R-wave associated with the right ventricle **115B** and the detection of the R-wave associated with left ventricle **115D**. Thus, if $(t_1 - t_0) > (t_2 - t_0)$, then electrode **130** is selected for delivering contraction-evoking stimulations. If $(t_1 - t_0) < (t_2 - t_0)$, then

electrode **135** is selected for delivering contraction-evoking stimulations. If $(t_1 - t_0) = (t_2 - t_0)$, then the electrode closest to the heart apex, such as electrode **130**, is selected for delivering contraction-evoking stimulations. As discussed above, in a further example, a threshold time difference, Δt , is used for making the comparison. Thus, if $(t_1 - t_0) > [(t_2 - t_0) + \Delta t]$, then electrode **130** is selected for delivering
5 stimulations. If $[(t_1 - t_0) + \Delta t] < (t_2 - t_0)$, then electrode **135** is selected for delivering stimulations. Otherwise the electrode closest to the heart apex, such as electrode **130**, is selected for delivering stimulations.

As discussed above, the time intervals $(t_1 - t_0)$ and $(t_2 - t_0)$ need not be measured during the same cardiac cycle, as illustrated in the graph of Figure 6. In
10 the example of Figure 6, a time interval $(t_1 - t_{0A})$ is measured during a first cardiac cycle and a time interval $(t_2 - t_{0B})$ is measured during a second (consecutive or nonconsecutive) cardiac cycle. In this example, if $(t_1 - t_{0A}) > (t_2 - t_{0B})$, then electrode **130** is selected for delivering contraction-evoking stimulations. If $(t_1 - t_{0A}) < (t_2 - t_{0B})$, then electrode **135** is selected for delivering contraction-evoking stimulations.
15 If $(t_1 - t_{0A}) = (t_2 - t_{0B})$, then the electrode that is closest to the apex of heart **115**, such as electrode **130**, is selected for delivering contraction-evoking stimulations. In a further example, as discussed above, a threshold time difference, Δt , is used for making the comparison. Thus, if $(t_1 - t_{0A}) > [(t_2 - t_{0B}) + \Delta t]$, then electrode **130** is selected for delivering stimulations. If $[(t_1 - t_{0A}) + \Delta t] < (t_2 - t_{0B})$, then electrode **135**
20 is selected for delivering stimulations. Otherwise, the electrode closest to the heart apex, such as electrode **130**, is selected for delivering stimulations. By measuring the time intervals during different cardiac cycles, a single sense amplifier can be multiplexed between electrodes **130** and **135** for detecting the depolarization fiducial points. In certain embodiments, this advantageously allows for reduced circuitry.
25 Although Figure 6 illustrates an embodiment in which a right ventricular depolarization fiducial point is used as a reference point for measuring the time intervals, such techniques for measuring time intervals separately during different

cardiac cycles is equally applicable to the other techniques discussed herein using other fiducial points.

Moreover, as discussed above, with respect to Figure 3, in a further embodiment, data is acquired over a plurality of cardiac cycles, and a statistical comparison of RV-LV time intervals, with or without using Δt for the comparison, is used to select the particular LV electrode for delivering contraction-evoking stimulations. In one embodiment, the subsequent contraction-evoking stimulation therapy is delivered without corresponding contraction-evoking stimulations delivered to right ventricle **115B**. However, in another embodiment, each subsequent contraction-evoking stimulation therapy delivered by the selected one of left ventricular electrodes **130** and **135** is accompanied by a corresponding appropriately timed stimulation delivered by right ventricular electrode **400**. This is referred to as biventricular cardiac resynchronization therapy. The stimulation delivered at the selected one of left ventricular electrodes **130** and **135** may be simultaneous to, or different from, the time of the corresponding stimulation delivered by right ventricular electrode **400**.

Figure 7 is a graph example of selecting one of the electrodes associated with the same heart chamber, such as left ventricle **115D**, using time intervals measured from a reference fiducial point obtained from one of the same electrodes associated with that heart chamber. In this example, a reference fiducial point is obtained at time t_{0A} by the first one of LV electrodes **130** and **135** to detect an onset of a QRS complex. This onset of the QRS complex, which is referred to as Q^* , serves as the reference fiducial point. One example of detecting Q^* is discussed in Ding et al. U.S. Patent No. 6,144,880, entitled "Cardiac Pacing Using Adjustable Atrio-Ventricular Delays," assigned to Cardiac Pacemakers, Inc., the entirety of which is incorporated herein by reference. The R-wave peak, or other fiducial point associated with a QRS complex, is detected at time t_1 at electrode **130**. A first time difference $t_1 - t_{0A}$ is measured. In this example, the same reference fiducial point is

again detected, during a subsequent consecutive or nonconsecutive cardiac cycle, at time t_{0B} by the first one of LV electrodes **130** and **135** to detect Q^* . The R-wave peak, or the other fiducial point similar to the fiducial point measured from electrode **130** at time t_1 , is detected at time t_2 at electrode **135**. A second time difference $t_2 - t_{0B}$ is measured. In this example, if $(t_1 - t_{0A}) > (t_2 - t_{0B})$, then electrode **130** is selected for delivering contraction-evoking stimulations. If $(t_1 - t_{0A}) < (t_2 - t_{0B})$, then electrode **135** is selected for delivering contraction-evoking stimulations. If $(t_1 - t_{0A}) = (t_2 - t_{0B})$, then the electrode closest to the apex of heart **115**, such as electrode **130**, is selected for delivering contraction-evoking stimulations. In a further example, as discussed above, a threshold time difference, Δt , is used for making the comparison.

Thus, if $(t_1 - t_{0A}) > [(t_2 - t_{0B}) + \Delta t]$, then electrode **130** is selected for delivering stimulations. If $[(t_1 - t_{0A}) + \Delta t] < (t_2 - t_{0B})$, then electrode **135** is selected for delivering stimulations. Otherwise, the electrode closest to the heart apex, such as electrode **130**, is selected for delivering stimulations. Although the example illustrated in Figure 7 relates to using multiple cardiac cycles, it is understood that this technique could be carried out during a single cardiac cycle using a single reference point t_0 substituted for the above reference points t_{0A} and t_{0B} . Moreover, because Q^* typically occurs substantially simultaneously at multiple electrodes associated with the same heart chamber, the Q^* reference fiducial point can typically be detected from any one of the multiple electrodes associated with the same heart chamber.

Figures 1 - 6 illustrate that selecting the particular electrode, from a plurality of electrodes associated with left ventricle **115D**, is in one embodiment based on the longer RA-LV measurement, and in another embodiment is based on the longer RV-LV measurement. In a further embodiment, selecting the particular electrode from a plurality of electrodes associated with the same ventricle is based on a time measurement from any selected reference fiducial point associated with any heart chamber to any other selected fiducial point associated with detection at the

electrodes of one depolarization of that ventricle. One such example is illustrated in Figure 7, in which a first left ventricular electrode detects a Q* fiducial point, then the second left ventricular electrode also detects the Q* fiducial points. Thus, the plurality of ventricular electrodes each detect the same type of fiducial point associated with the ventricular heart contraction. For example, if a first left

5 ventricular electrode detects the R-wave peak, then the second left ventricular electrode also detects the R-wave peak. In another embodiment, if the first left ventricular electrode detects the point of maximum slope associated with a left ventricular R-wave, then the second left ventricular electrode also detects the point of maximum slope associated with the left ventricular R-wave. Stated differently,

10 the left ventricular fiducial points are substantially similarly located on received heart depolarizations or, alternatively, may be located at different portions of the heart depolarization signal if the expected time interval between these different locations is known. Figures 1 - 6 particularly describe using P-wave and R-wave peaks as fiducial points, however, other examples of possible fiducial points

15 include, among other things, a point of minimum slope on the detected heart signals. Moreover, as discussed above, the relative timing of the fiducial point detected at each same-chamber electrode can be compared directly, without using a reference fiducial point to establish corresponding time intervals as discussed above with respect to certain embodiments.

20 Moreover, in an alternative embodiment, for a heart 115 in which the electrical pathways cause the left ventricle to contract before the right ventricle, a left ventricular to right ventricular (LV-RV) delay is measured at a plurality of right ventricular electrodes, and subsequent contraction-evoking stimulations are delivered from that right ventricular electrode corresponding to the longest LV-RV

25 delay. Thus, in a broader sense, a particular electrode from a plurality of electrodes associated with a first ventricle is selected for subsequent therapy delivery based on that electrode having a later detected depolarization than the other electrodes in the

plurality of electrodes. In a further embodiment, system **100** not only selects between multiple electrodes associated with the same heart chamber, but also selects between right ventricle **115B** and left ventricle **155D** for delivering the contraction-evoking stimulations, such as described in Ding et al. U.S. Patent Application No. 09/738,407, assigned to Cardiac Pacemakers, Inc., the disclosure of which is
5 incorporated herein by reference in its entirety.

It is to be understood that the above description is intended to be illustrative, and not restrictive. For example, the above-described embodiments may be used in combination with each other. Many other embodiments will be apparent to those of skill in the art upon reviewing the above description. The scope of the invention
10 should, therefore, be determined with reference to the appended claims, along with the full scope of equivalents to which such claims are entitled. In the appended claims, the terms “including” and “in which” are used as the plain-English equivalents of the respective terms “comprising” and “wherein.”